Increasing preparedness for LGBTQ+ behavioral healthcare provision via a virtual clinical module

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Background and Introduction

Lesbian, gay, bisexual, transgender, queer or other sexual or gender minority (LGBTQ+) individuals are subject to unique health concerns including lower rates of preventive care, higher rates of HIV and STIs, higher rates of unhealthy weight control, higher rates of depression and anxiety, and higher susceptibility to risk-taking behaviors such as smoking and substance use. Specifically, transgender individuals experience higher rates of these health disparities compared to the rest of the LGBTQ+ community. These disparities are likely both rooted in, and exacerbated by, negative healthcare experiences such as verbal harassment, denial of equal treatment, or even physical assault. Less overtly, transgender patients report a high incidence of negative experiences due to perceived provider discomfort.

Preparation to care effectively for LGBTQ+ patients should begin in medical school yet is often lacking. A previous survey of medical school deans indicated a wide variety of instruction time for LGBTQ+ specific healthcare in their schools' curricula with a median of five hours. A previous study of medical students in the United States and Canada suggested most medical students evaluated their LGBT-related curriculum as "fair" or worse and that students had significant concerns in addressing certain aspects of LGBTQ+ health. This survey found that self-reported preparedness was lowest for transgender-specific health topics such as "transitioning" and "sex reassignment surgery."

In this study, we examined how the virtual, interactive clinical module and group discussion impacted students' reported preparedness in treating patients who identify as LGBTQ+. Designed for the required psychiatry clerkship, the module focused on the experience of a transgender man in an inpatient psychiatric hospital. The responses of participating third-year medical students to a pre- and post-module survey were analyzed retrospectively.

Virtual Module Overview

The module began with an anonymous pre-module survey using Qualtrics. Next, students completed an ungraded matching exercise as a review of rudimentary terminology. Before beginning the clinical vignette, students were prompted to pause and independently reflect on how they came to know their own sexual orientation, gender identity, or status; no responses were solicited regarding their reflection. The clinical vignette follows a transgender man brought to an inpatient psychiatric hospital by the police after a suicide attempt. The vignette has students order tasks for a psychiatric intake, takes them through the initial interview, and then asks for a preliminary diagnosis. The module also instructs students to identify the primary biopsychosocial contributors to the patient's suicide attempt, treatment recommendations, and resources to provide the patient. Students were then given a list of local resources for LGBTQ+ individuals and links to optional further reading.

Students were next required to post answers to questions on a virtual discussion board about implicit biases that may occur when caring for transgender patients, treatment interventions for the vignette patient, and their reflections on healthcare providers' role in the "coming out" process. The students worked in small groups to create presentations on clinical considerations for hormone therapy and how a physician can enhance or decrease the likelihood a patient will be forthcoming about their sexual orientation, gender identity, and/or status with them. These presentations were discussed in an online video conference led by faculty. Finally, the students were asked to complete the same anonymous survey completed prior to the module. The survey was not part of students' grades and each question had a "decline to answer" option.

Survey Analysis

Surveys assessed students' perceptions of their own comfort and preparedness for healthcare interactions with LGBTQ+ patients and the effects, if any, of their medical school curriculum on comfort and preparedness. Descriptive data (frequency) is used to measure the students' responses. A coding scheme based on combined similar topics provided in the open-ended responses was created and used to group responses into predominant themes. All the entries, partial or complete, documented on Qualtrics are considered in the analysis.

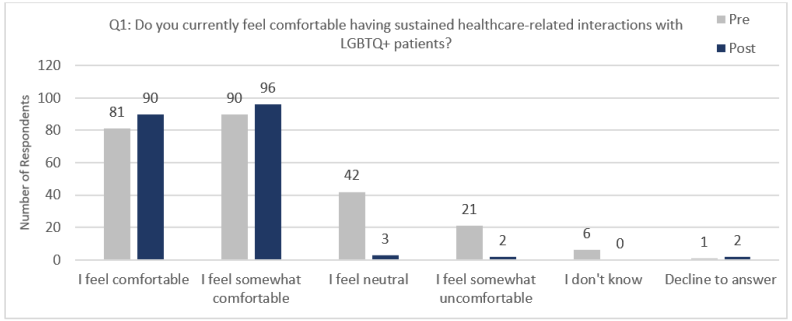

FIGURE 1. Baseline levels of reported comfort with sustained healthcare-related interactions with LGBTQ+ patients were high. After the module, there was a slight increase in number of *comfortable* or *somewhat comfortable*

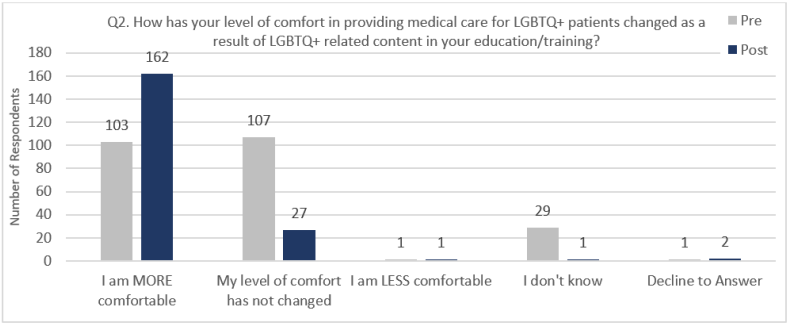

FIGURE 2. Respondents were roughly split equally between reporting the LGBTQ+ related content in their training had made them *more comfortable* providing medical care for LGBTQ+ patients and their comfort level had *not changed.* After completion of the module, however, a majority of students credited their education/training for increasing their comfort levels.

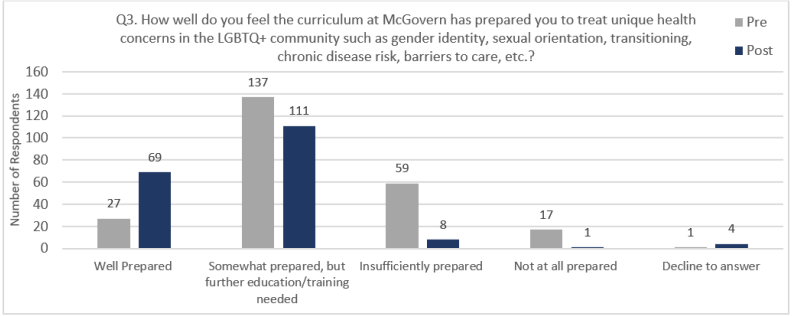

FIGURE 3. A small minority of students indicated their school's curriculum had *well prepared* them to treat unique health concerns in the LGBTQ+ community. After the module, respondents who self-reported being *well prepared* increased (n=69 vs n=27 pre-module).

Results

A majority of respondents selected *comfortable* (34%, n=81) or *somewhat comfortable* (37%, n=90) having sustained healthcare-related interactions with LGBTQ+ patients prior to the module (Figure 1). After the module, there was a slight increase in number of *comfortable* (47%, n=90) or *somewhat comfortable* (50%, n=96, Figure 1). Respondents were split roughly equally between reporting the LGBTQ+ related content in their training had made them *more comfortable* (40%, n=103) providing medical care for LGBTQ+ patients and their comfort level had *not changed* secondary to their education (44%, n=107). A single respondent felt the training had made them *less comfortable* (Figure 2). After completion of the module, however, a majority of students credited their education/training for increasing their comfort levels (84%, n=162), while 14% reported the curriculum had not affected their comfort levels (n=27, Figure 2). Only 11% (n=27) of students indicated their school's curriculum had *well prepared* them to treat unique health concerns in the LGBTQ+ community (Figure 3). A majority (57%, n=137) responded *somewhat prepared* (Figure 3). Finally, 32% (n=76) answered *insufficiently* or *not at all prepared* (Figure 3). After the module, respondents who self-reported being *well prepared* increased to 36% (n=69 vs n=27 pre-module) and only 6% still reported feeling *insufficiently* or *not at all prepared* (n=9 vs n=76 pre-module; Figure 3). The percentage of students responding *somewhat prepared but further education/training needed* remained 57% (n=111 vs n=137 pre; Figure 3).

The final question was open-ended and asked respondents to reflect on what had been most influential to their comfort level, or lack thereof, in providing medical care for LGBTQ+ patients. Many students referenced the lectures given during pre-clinical years or personal connections to the LGBTQ+ community as their only exposure to LGBTQ+ health issues prior to this module. These responses were often accompanied by concerns about respondents' own lack of medical knowledge (health issues and best practices) specific to the community.

One of the most common themes before and after the module was need for practice in a clinical setting. Those who had the opportunity to practice treating LGBTQ+ patients in the community cited those experiences as being especially influential, but many reported never having interacted with an LGBTQ+ patient. Besides treating more LGBTQ+ patients on their rotations, respondents indicated this lack of experience could be remedied by electives dedicated to LGBTQ+ health, LGBTQ+ patients presenting on their healthcare experiences, or qualified physicians sharing clinical stories.

Another frequent answer pre and post module was that education on terminology relevant to the LGBTQ+ community increased student comfort. Multiple post-module respondents referenced instruction on how to inquire about and use patients' pronouns when interacting with patients as particularly useful. Several also desired training on how to ask "hard questions" or approach "sensitive topics" appropriately in order to create a sense of safety for patients during clinical interactions.

Conclusions

LGBTQ+ individuals continue to face health disparities and negative experiences with medical providers. Though many third-year medical students in our study reported perceived comfort with sustained healthcare interactions with LGBTQ+ patients, far fewer reported feeling well-prepared to treat unique health concerns of the LGBTQ+ community such as gender identity, sexual orientation, transitioning, chronic disease risk, barriers to care, etc. Students credited their medical school curriculum with increasing their comfort with this population and suggested specific education modalities that increased their comfort or could be effective in resolving their lack of comfort. These results suggest LGBTQ+ specific healthcare instruction in medical education curriculum is both desired and perceived as effective for increasing comfort and preparedness in treating this population. Group discussion, training on LGBTQ+ terminology, and practice in a clinical setting should be prioritized in developing these curricula. Clinical vignettes highlighting LGBTQ+ patients like the one used in this study, even in general medical educational content, can be easily incorporated into existing clerkships, problem-based learning, standardized patient encounters, and/or traditional lectures.

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